State of Connecticut
GENERAL ASSEMBLY

COMMISSION ON CHILDREN

Testimony of
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Select Committee on Children
Public Hearing
February 23, 2006

Senator Meyer, Representative Cardin, and Members of the Select Committee:

Thank you for this opportunity to testify on behalf of the Connecticut Commission on Children concerning several bills before the Select Committee on Children. I am writing in support of Raised Bills 200, 202, 204 and 5252.

Child Wellness Legislation

Childhood obesity has entered our civic discourse with a bang. We frequently recite the alarming statistics that have entered our vocabulary since the U.S. Surgeon General labeled this condition a public health epidemic.

- Nationally the prevalence of overweight children nearly doubled in the past 20 years and nearly tripled for adolescents.
- Adult obesity in Connecticut has nearly doubled in just over a decade – from 10.9% in 1991 to 18.0% in 2002. Most Connecticut adults (54.8%) are overweight or obese.
- Most obese children grow up to be obese adults and suffer from the conditions associated with obesity, including heart disease, stroke and diabetes.
- Obese children are more likely to smoke, consume alcohol and experiment with drugs as well as have self-esteem and health issues which negatively impact their studies and social life in school.
- Obesity has costly direct and indirect consequences for families, health systems and the government programs that pay for emergency and long-term illness care. Obesity is associated with premature death and disability, increased health care costs and lost productivity.
- In Connecticut, obesity-related health problems for adults cost an estimated $856 million in annual medical expenses.

To see how difficult and long-term this issue will be to solve, take a look at the issue from the perspective of young people themselves.

When it comes to nutrition and exercise, children today have the deck stacked against them. In the old days, many students would walk to school, enjoy a healthy recess and physical education class, play late at the local park, and eat healthy home-cooked meals with vegetables from the garden behind their home. Our generation spent many hours getting fresh air and moving around outside, and we digested lots of real food. No wonder so few children and teens were overweight.

Today, children have little chance of walking to school. They are more likely to live several miles from school and to have to get a ride there and everywhere. For those who do live within walking distance from school, there is a pretty good chance that the walk is too dangerous – due to fast-moving traffic, a lack of sidewalks or the risk of crime. Although we know from research how important regular exercise is to education, busy school days often leave only a few minutes for outside play. And students too often eat unhealthy food, both at school and in restaurant or take-out food when busy parents don't have time to cook. In fact, healthy foods such as raw fruits and vegetables, or even prepared foods with low fat content are more expensive and more difficult to locate. After school each day, television, computer and video games compete for attention, overshadowing more active options like hopscotch and soccer.

It is really no surprise then that thousands of Connecticut children are overweight or at risk of becoming overweight, and that an increasing number are at risk for Type 2 diabetes. We used to call this adult-onset diabetes, but the disease has become so common among young people that you don't often hear it called that anymore.

With the help of this Select Committee's leaders and others, over the past year Connecticut has begun to take the obesity issue very seriously. I am pleased to report several positive developments. The Connecticut Department of Public Health (DPH) and the Department of Education (SDE) have both published important state plans for healthy living and eating. DPH has added obesity staff, and with the Commission on Children (COC) DPH has announced plans for a state advisory council to focus on childhood obesity prevention. School districts across the state are developing wellness policies to be in place by this fall. COC and the Connecticut Conference of Municipalities are working with mayors who want to take the lead in strengthening the health of their community's children. Yale University has opened the Rudd Center, an obesity resource center that is providing assistance throughout the state. All around the state, innovative solutions to this problem are emerging – from family walking programs in Norwalk, pedestrian trails in Mansfield, and a school food pilot program in New Haven to farmer's markets in East Hartford and Stratford.

Energy is building around media health promotion, school-based nutrition, education and physical activity programs, programs for parents and caregivers, neighborhood and community planning and training for medical professionals.

While we celebrate the progress being made, this is a long-term issue that took decades to emerge and that will take dedicated attention for years to solve. We need to take action this year, and the next, and the year after. Recall the long-term campaigns on tobacco prevention or child safety seats. It will take a long time to restore health to our state's children.

The legislation before you is an excellent next step.

R.B. 202 would expand school breakfasts to all severe need schools serving children in grades eight or under. Providing nutritious breakfasts and lunches for students has a beneficial impact on students' academic performance, attendance and health. Eating breakfast at school helps kids do better on math and reading tests, even better than kids who eat at home.

Connecticut ranks last in the nation – even behind the District of Columbia – in the number of schools participating in the School Breakfast Program as well as very low on the number of participating students. Less than 50 percent of the schools in Connecticut that offer the School Lunch Program also provide school breakfast. This is unacceptable, and the bill takes appropriate steps to improve program participation. We strongly support the bill.

R.B. 204 would require school districts to establish a plan to address the physical, mental, social and emotional health needs of students. This bill follows the release of an SDE report for schools on how to develop the federally required local wellness policy that must be in place by September 2006. It would provide state guidelines to help school districts encourage physical activity by students, coordinate health programs for students, maximize resources to improve student health, and take other steps to improve student health. We support the bill.

R.B. 5252 would require schools to offer students in grades K-5 at least twenty minutes of physical exercise each school day. This is a reasonable requirement; nearly all schools already offer such an opportunity. For the other schools, physical activity can be incorporated into classroom study as a series of brief exercise interludes between academic courses. Students should have at least a few minutes a day to stretch and be active, and these brief periods of exercise can contribute to more focused and effective study. We strongly support this bill. We would offer the suggestion that the title is misleading: the bill calls for 20 minutes of opportunity for physical activity, not physical education.

We have two suggestions to amend the legislation before you.

Statewide obesity trend data

We strongly recommend that language be added to the legislation before you to measure statewide and local progress toward reducing the incidence of childhood obesity. You will notice that this testimony began with statistics, but there were no Connecticut youth obesity statistics. That is because no such official statistics exist. The state only has limited unofficial statistics from individual communities and broad statewide estimates based on national data.

We should chart our state’s progress in preventing obesity by providing for statewide Body Mass Index (BMI) data collection and analysis. According to the Centers for Disease Control and Prevention, BMI-for-age is the best way to measure student progress. In Connecticut, SDE already asks pediatricians to fill in each student’s BMI on the school health assessment form.

The attached language would create a partnership between the schools, SDE and DPH to use the school health assessment form data to chart annual BMI trends for students. This would be aggregate data – completely confidential and without any health "report card" – as the state

already does for asthma and immunization. We strongly encourage the Select Committee to add this language to the legislation before you.

State Childhood Obesity Council

We also recommend that the Select Committee reintroduce its 2005 bill that would create a statutory state childhood obesity council (Substitute H.B. 6631, File Version 203). This legislation would support the emerging DPH-COC partnership by drawing government and non-government leaders together to help implement a common strategy to prevent childhood obesity. Other states have taken a similarly comprehensive approach to coordination on this issue.

Gender-Specific and Trauma-Informed Behavioral Health and Substance Abuse Services

The Commission supports **R.B. 200**, a bill to require that behavioral health and substance abuse services supported by the state are gender-specific and trauma informed. It makes no sense to provide such services without paying attention to the consequences of domestic violence, sexual assault and related trauma. This bill would help victims by requiring attention to these issues and supporting the use of best practices in the delivery of these services.

Conclusion

Thank you for this opportunity to present the views of the Commission on Children on these important bills. We look forward to working with the Select Committee to ensure that every child has a healthy and fair start in life.

Recommended childhood obesity legislative language on statewide Body Mass Index (BMI) data collection

Section 1. Section 10-206 is repealed and the following is substituted:

(a) Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments pursuant to the provisions of this section. Such assessments shall be conducted by a legally qualified practitioner of medicine, an advanced practice registered nurse or registered nurse, licensed pursuant to chapter 378, a physician assistant, licensed pursuant to chapter 370, or by the school medical advisor to ascertain whether such pupil is suffering from any physical disability tending to prevent such pupil from receiving the full benefit of school work and to ascertain whether such school work should be modified in order to prevent injury to the pupil or to secure for the pupil a suitable program of education. No health assessment shall be made of any child enrolled in the public schools unless such examination is made in the presence of the parent or guardian or in the presence of another school employee. The parent or guardian of such child shall receive prior written notice and shall have a reasonable opportunity to be present at such assessment or to provide for such assessment himself or herself. A local or regional board of education may deny continued attendance in public school to any child who fails to obtain the health assessments required under this section.

(b) Each local or regional board of education shall require each child to have a health assessment prior to public school enrollment. The assessment shall include: (1) A physical examination which shall include hematocrit or hemoglobin tests, height, weight, blood pressure, and, beginning with the 2003-2004 school year, a chronic disease assessment which shall include, but not be limited to, asthma as defined by the Commissioner of Public Health pursuant to subsection (c) of section 19a-62a and, beginning with the 2006-2007 school year, body mass index-for-age as defined by the Commissioner of Public Health pursuant to section 2 of this bill. The assessment form shall include (A) **[**a**]** check boxes for the provider conducting the assessment, as provided in subsection (a) of this section, to indicate an asthma diagnosis and body mass index-for-age, (B) screening questions relating to appropriate public health concerns to be answered by the parent or guardian, and (C) screening questions to be answered by such provider; (2) an updating of immunizations as required under section 10-204a, provided a registered nurse may only update said immunizations pursuant to a written order by a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378; (3) vision, hearing, speech and gross dental screenings; and (4) such other information, including health and developmental history, as the physician feels is necessary and appropriate. The assessment shall also include tests for tuberculosis, sickle cell anemia or Cooley's anemia and tests for lead levels in the blood where the local or regional board of education determines after consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, that such tests are necessary, provided a registered nurse may only perform said tests pursuant to the written order of a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378.

(c) Each local or regional board of education shall require each pupil enrolled in the public schools to have health assessments in either grade six or grade seven and in either grade ten or grade eleven. The assessment shall include: (1) A physical examination which shall include hematocrit or hemoglobin tests, height, weight, blood pressure, and, beginning with the 2003-

2004 school year, a chronic disease assessment which shall include, but not be limited to, asthma as defined by the Commissioner of Public Health pursuant to subsection (c) of section 19a-62a and, beginning with the 2006-2007 school year, body mass index-for-age as defined by the Commissioner of Public Health pursuant to section 2 of this bill. The assessment form shall include (A) **[**a**]** check boxes for the provider conducting the assessment, as provided in subsection (a) of this section, to indicate an asthma diagnosis and body mass index-for-age, (B) screening questions relating to appropriate public health concerns to be answered by the parent or guardian, and (C) screening questions to be answered by such provider; (2) an updating of immunizations as required under section 10-204a, provided a registered nurse may only update said immunizations pursuant to a written order of a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378; (3) vision, hearing, postural and gross dental screenings; and (4) such other information including a health history as the physician feels is necessary and appropriate. The assessment shall also include tests for tuberculosis and sickle cell anemia or Cooley's anemia where the local or regional board of education, in consultation with the school medical advisor and the local health department, or in the case of a regional board of education, each local health department, determines that said screening or test is necessary, provided a registered nurse may only perform said tests pursuant to the written order of a physician or physician assistant, licensed pursuant to chapter 370, or an advanced practice registered nurse, licensed pursuant to chapter 378.

(d) The results of each assessment done pursuant to this section and the results of screenings done pursuant to section 10-214 shall be recorded on forms supplied by the State Board of Education. Such information shall be included in the cumulative health record of each pupil and shall be kept on file in the school such pupil attends. If a pupil permanently leaves the jurisdiction of the board of education, the pupil's original cumulative health record shall be sent to the chief administrative officer of the school district to which such student moves. The board of education transmitting such health record shall retain a true copy. Each physician, advanced practice registered nurse, registered nurse, or physician assistant performing health assessments and screenings pursuant to this section and section 10-214 shall completely fill out and sign each form and any recommendations concerning the pupil shall be in writing.

(e) Appropriate school health personnel shall review the results of each assessment and screening as recorded pursuant to subsection (d) of this section. When, in the judgment of such health personnel, a pupil, as defined in section 10-206a, is in need of further testing or treatment, the superintendent of schools shall give written notice to the parent or guardian of such pupil and shall make reasonable efforts to assure that such further testing or treatment is provided. Such reasonable efforts shall include a determination of whether or not the parent or guardian has obtained the necessary testing or treatment for the pupil, and, if not, advising the parent or guardian on how such testing or treatment may be obtained. The results of such further testing or treatment shall be recorded pursuant to subsection (d) of this section, and shall be reviewed by school health personnel pursuant to this subsection.

(f) On and after February 1, 2004, each local or regional board of education shall report to the local health department and the Department of Public Health, on an annual basis, the total number of pupils per school and per school district having a diagnosis of asthma, and, on and after February 1, 2008, the total number of pupils per school and per school district who are underweight, at risk for overweight, or overweight based on body mass index-for-age (1) at the time of public school enrollment, (2) in grade six or seven, and (3) in grade ten or eleven. The

report shall contain the asthma and body mass index-for-age information collected as required under subsections (b) and (c) of this section and shall include pupil age, gender, race, ethnicity and school. On and after February 1, 2008, each local or regional board of education shall report to the local health department and the Department of Public Health, on an annual basis, (1) the number of students receiving a pediculosis, nutrition, mental health or dental screening, or any other screening as determined by the Department of Education, (2) the number of such students referred to an outside provider as a result of the screening, and (3) such other health services program information as determined by the Department of Education, in consultation with the Department of Public Health.

(g) Beginning on October 1, 2004, and every three years thereafter, the Department of Public Health shall review the asthma screening information reported pursuant to this section and shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education concerning asthma trends and distributions among pupils enrolled in the public schools. Beginning on October 1, 2008, and annually thereafter, the Department of Public Health shall review the body mass index-for-age information reported pursuant to this section and shall submit a report to the joint standing committees of the General Assembly having cognizance of matters relating to public health and education concerning overweight and obesity trends and distributions among pupils enrolled in the public schools, and making recommendations to address health concerns identified in the report. Each **[**The**]** report required pursuant to this subsection shall be submitted in accordance with the provisions of section 11-4a and shall include, but not be limited to, trends and findings based on pupil age, gender, race, ethnicity, school and the education reference group, as determined by the Department of Education for the town or regional school district in which such school is located.

Sec. 2. (NEW) (a) Not later than January 1, 2008, the Commissioner of Public Health shall establish and maintain a system of monitoring physical development and growth of Connecticut students. Such system shall include, but not be limited to, annual collection of student age and gender, height and weight, and body mass index-for-age. The monitoring system may include reports of the number of students overweight, at risk for overweight, or underweight in the state. Such system shall be used by the Commissioner in estimating annual incidence and distribution of overweight or at risk of overweight students in the state, including, but not limited to, such incidence and distribution based on age, gender, grade, school enrollment and the education reference group, as determined by the Department of Education, of the town or regional school district.

(b) Not later than October 1, 2006, the Commissioner of Public Health shall develop model case definitions of body mass index and body mass index-for-age for purposes of this section and section 10-206.